BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

JOSE M. AMAYA Claimant	)	
VS.	)	
SOLOMON CORPORATION Respondent	)	Docket No. 1,053,203
AND	)	
ZURICH AMERICAN INSURANCE CO. Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Claimant requested review of the June 6, 2011, Award entered by Administrative Law Judge Bruce E. Moore. The Board heard oral argument on September 7, 2011. The Director appointed E.L. Lee Kinch to serve as Appeals Board Member Pro Tem in place of former Board Member Julie A.N. Sample. David O. Alegria, of Topeka, Kansas, appeared for claimant. Kendall R. Cunningham, of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

The Administrative Law Judge (ALJ) found that claimant has a 5 percent impairment to his left upper extremity at the level of his hand. In addition, the ALJ found that claimant has a 20 percent permanent impairment to his shoulder but determined the left shoulder condition was not a natural and probable consequence of his work-related accident.

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

Claimant asks that the Award of the ALJ be modified, arguing that his left shoulder adhesive capsulitis is a natural and probable consequence of his work-related accident of July 22, 2009. During oral argument to the Board, claimant agreed with the percentage of

permanent impairment found by the ALJ, to-wit: 5 percent to the hand and 20 percent to the shoulder.

Respondent contends the Award of the ALJ should be affirmed.

The issue for the Board's review is: Is claimant's left shoulder condition a natural and probable consequence of his work-related accident of July 22, 2009?

FINDINGS OF FACT

Claimant worked for respondent, a company that recycles transformers, since 1999. On July 22, 2009, some crushed containers hit his left hand against the inside of a dumpster, injuring his little finger. Three days later, he went to the hospital for treatment, where it was found he had fractured his left little finger. His hand was placed in a cast, and he was given an appointment to see Dr. David Peterson, a board certified orthopedic surgeon. However, claimant said he had problems with his finger and, on his own, put a wood splint on it to hold the cast to his finger.

Dr. Peterson saw claimant for the first time on August 5, 2009. Claimant had fractured his left little finger just below the joint that connects the finger to the hand. He removed claimant's original cast and replaced it with a short arm cast that went half way or two-thirds the way up claimant's forearm. Claimant's fingers were slightly bent. Claimant was using a splint at the time of the August 2009 office visit and told Dr. Peterson he had been using the splint for about a week. Dr. Peterson assumed the splint had been prescribed for claimant by another doctor.

Dr. Peterson saw claimant again on September 9, 2009, at which time he felt the fracture had healed to a point where claimant could begin rehabilitation. The cast was removed, and claimant was referred to occupational therapy and for range of motion strengthening. From a radiological point of view, Dr. Peterson said that claimant's fracture was healed as of September 2009. He gave claimant temporary restrictions of light duty with lifting restricted to 20 pounds to bench level and 5 pounds overhead.

Dr. Peterson next saw claimant on October 1, 2009. Claimant had not begun occupational therapy. Claimant complained he was still having pain with motion and that movement was tight. But Dr. Peterson released claimant to full duty as of October 2, 2009.

Dr. Peterson next saw claimant on November 17, 2009. Claimant's range of motion was much improved. Dr. Peterson said that in terms of functionality, claimant could grip. Claimant's x-rays were normal. Dr. Peterson said claimant complained about pain around his wrist in an area on the thumb side. Dr. Peterson x-rayed that area but saw nothing that would have caused any discomfort. Claimant made no other complaints of pain in any part of his upper extremity or shoulder.

By stipulation between the parties, claimant's physical therapy notes were made a part of the record of this case. On November 19, 2009, claimant's therapist indicated that claimant was still wearing a Velcro splint and carried his left hand close to the body when he entered the treatment room. The therapist suspected claimant was not using his hand at home and asked claimant to stop wearing the splint to encourage range of motion and strengthening.

Dr. Peterson saw claimant again on December 8, 2009. Claimant had continued with physical therapy, and it appeared the therapy had been beneficial, although claimant had some loss of flexion at the MCP joint. Dr. Peterson indicated the loss of range of motion was not caused by a physical abnormality but was soft tissue tightness. Dr. Peterson rated claimant as having a 15 percent impairment of his little finger, which converted to 2 percent of the hand, for loss of range of motion. This was based on an 8 percent impairment for the PIP joint and 8 percent for the MCP joint (which combine for a 15 percent to the little finger).[1]

During his treatment, Dr. Peterson did not place claimant's hand or finger in a splint, nor did he ever recommend use of a sling.

Claimant testified he was surprised when he was released with no restrictions by Dr. Peterson because he felt he was still injured. He said he was having pain from his wrist to his elbow and from his elbow to his shoulder area. He testified he told Dr. Peterson about his elbow and shoulder problems in January 2010[2]. Claimant said after his release from treatment, he conferred with his attorney and an appointment was made for him to again see Dr. Peterson in April 2010.

Dr. Peterson saw claimant on April 28, 2010. At that time, claimant was complaining of pain in his left shoulder and elbow. Claimant told Dr. Peterson the pain began in January 2010 with no specific injury. Claimant told Dr. Peterson that he was no longer having pain in his wrist. Dr. Peterson was not able to determine that anything was wrong with claimant's elbow. Dr. Peterson did not see that claimant had a shoulder injury; claimant just had restricted motion. He referred claimant to physical therapy. He also recommended claimant use a cane or broom handle to lift up in order to try to break up the adhesions that caused the frozen shoulder. Claimant's physical therapy notes of May 5, 2010, indicate that claimant said he began to have increased left shoulder pain in January 2010.

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[1] There is no mention in the deposition that this rating was based on the AMA *Guides*.

[2] Dr. Peterson did not see claimant in January 2010.

Claimant returned to see Dr. Peterson on June 2, 2010. He had not progressed under physical therapy. Claimant was scheduled to return in three weeks, but Dr. Peterson has no notation that claimant ever returned.

Dr. Peterson said the shoulder is the most mobile joint in the body and is subject to forming adhesions that cause frozen shoulder. Dr. Peterson said sometimes people just wake up with frozen shoulder or get it after having bumped his or her shoulder, although he had no indication that claimant bumped either his elbow or shoulder. Dr. Peterson opined that claimant's shoulder condition was not related to the injury of July 22, 2009. If it were related, Dr. Peterson said it would have appeared earlier. Dr. Peterson would have expected that claimant would have noticed pain in his shoulder, elbow or wrist when the pain from the acute fracture went away. And in fact, claimant did complain about pain in his wrist. But from the time Dr. Peterson treated claimant in August 2009 until he rated claimant in December 2009, there was no indication that claimant had pain in any body part other than the fracture site and his wrist.

Dr. Peterson agreed with claimant's attorney that adhesive capsulitis can be caused by not using an extremity. He also agreed that claimant's adhesive capsulitis likely developed as a result of his limited use of the upper extremity. However, Dr. Peterson did not believe it was related to the accident because of when the adhesive capsulitis developed–January 2010. Dr. Peterson opined that if claimant was holding his arm near his side, not raising it and not using it as one would regularly use it, he would have noticed symptoms of adhesive capsulitis in about three months, or by October 2009.

Dr. C. Reiff Brown, a retired certified orthopedic surgeon, examined claimant on October 13, 2009, at the request of claimant's attorney. Claimant reported he sustained a crush injury to his left hand and a fracture of his little finger while at work. Claimant told Dr. Brown that Dr. Peterson had treated him initially with splinting, then casting, and physical therapy. Claimant told Dr. Brown he had pain in his wrist joint and in the area of the little finger. He complained of loss of range of motion in the joints of the little finger, as well as pain when he attempted to move it into a position of flexion.

In his examination, Dr. Brown found claimant had mild swelling at the distal aspect of the fifth metacarpal. Claimant had loss of range of motion in the MP joint, the PIP joint and DIP joint of the fifth finger. Claimant also had loss of range of motion in his left wrist. Dr. Brown found no other abnormalities. Dr. Brown reviewed x-rays and opined that clinical healing of claimant's fracture had taken place.

Dr. Brown noticed claimant was wearing a Velcro attached splint to support the smaller two fingers and the wrist. Dr. Brown said claimant should wear the splint if he was doing anything vigorous. He believed that claimant could safely return to work and use his left hand as long as he had the splint on and did not try to lift over 10 pounds with the left hand.

Claimant did not complain of any shoulder problems when Dr. Brown saw him in October 2009. Dr. Brown said there would have been no medical reason for claimant to have used a sling in October 2009. Dr. Brown opined claimant would not regain as much movement of his hand, wrist or shoulder if he continued to carry the arm immobilized for a longer period of time than necessary. He said there was a good chance a shoulder joint eventually would have restriction of movement if it was immobilized by carrying it in a sling.

Claimant's attorney asked Dr. Brown to examine claimant a second time, and this examination was performed on April 7, 2010. At that time, claimant indicated that he had additional physical therapy, during which time he developed pain that extended from his left hand and wrist upward to involve the left shoulder. Claimant complained of progressive loss of range of movement of the shoulder. He said he mentioned shoulder pain to the physical therapist but no treatment was provided. Dr. Brown examined claimant's left shoulder, finding tenderness and severe limitation of range of motion. There was crepitus on active movement.

Dr. Brown said if the shoulder is not moved, it is fairly common to see a loss of movement of the shoulder joint when there is extensive treatment being given to the distal part of the extremity.

> The problem is that everybody's attention, and especially the patient's attention, is directed to the problem, say, as in this case the fifth finger and the wrist, and no one thinks to observe what's going on in the shoulder. As in this case, it's fairly often that shoulders become stiff in cases that have rather extensive injuries distally.[3]

Dr. Brown said although there could have been some injury to the shoulder joint in the work accident, the most likely scenario, which he expressed within a reasonable degree of medical certainty, was that the shoulder condition developed later on.

Dr. Brown agreed with respondent's attorney that there is nothing in his medical records about a problem with claimant's shoulder until his examination of claimant on April 7, 2010. Claimant did not give Dr. Brown a specific time frame that the shoulder problems began to develop. Dr. Brown said if someone is going to develop adhesive capsulitis as a result of a hand fracture, such as in this case, he would expect those problems to appear within six weeks to two months. Dr. Brown would have expected claimant to have had shoulder difficulties in October 2009, when he first saw claimant, and by December 2009, when Dr. Peterson saw claimant. Dr. Brown testified it was possible that the shoulder problems could have been there and claimant simply was not aware of it, possibly because he had not tried to raise his arm up enough to make it hurt.

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[3] Brown Depo. at 19.

Dr. Brown opined that claimant suffered a fracture of the fifth metacarpal on July 22, 2009, which resulted in residual loss of function of the fifth finger due to capture fibrosis and possibly some degree of malunion of the fracture. He testified that claimant also had a loss of movement of the left wrist that had improved since October 2009. He also said that claimant had developed rotator cuff tendonitis acromial impingement syndrome with severe loss of range of motion of the left shoulder. He believed this was most likely due to the lack of movement of the shoulder during the healing period of claimant's left hand injuries. He recommended further treatment to claimant's left shoulder in the form of a referral to an orthopedic surgeon, who should also re-evaluate the wrist and finger. He recommended claimant have physical therapy for his shoulder.

Dr. Brown recommended that claimant avoid use of the right[4] hand above chest level on a frequent basis and frequent reach away from the body more than 18 inches with his left hand. He believes claimant should avoid work that involved frequent flexion and extension of the left wrist greater than 30 degrees. And he believed claimant would be unable to tightly grasp with the left hand.

Based on the AMA *Guides*,[5] Dr. Brown rated claimant as having an 18 percent permanent partial impairment to the left upper extremity for loss of range of motion. Further, he found claimant had a 30 percent impairment to the left fifth digit for loss of range of motion to the DIP joint; a 57 percent impairment of the left fifth digit for loss of range of motion at the PIP joint, and a 12 percent impairment of the left fifth digit for loss of range of motion of the MP joint. Those combined to a total 74 percent permanent partial impairment of function to the left fifth digit, which converts to a 7 percent permanent partial impairment of function to the left hand, which would then convert to a 6 percent impairment of function of the left upper extremity. This 6 percent, added to the 18 percent for loss of range of motion, combine for a total 23 percent functional impairment of the left upper extremity.

Dr. George Lucas, an orthopedic surgeon, evaluated claimant on November 15, 2010, at the request of the ALJ. Claimant gave him a history of being injured when his left hand was crushed between scrap iron and a container. Claimant had a soft tissue injury to his left hand and a fracture of the fifth metacarpal. Claimant also told Dr. Lucas that sometime between October 2009, when he was seen by Dr. Brown, and April 2010, he began to notice pain and limitation in his left shoulder. At the time Dr. Lucas saw claimant, claimant was wearing a splint on his hand and had his arm in a sling. Dr. Lucas said his impression was that claimant had continued to use the sling since he had gotten hurt. Dr. Lucas did not

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[4] This was probably an error, and it was claimant's left hand that was injured in the work-related accident.

[5] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

notice in any of claimant's medical records that any physician had recommended the use of a sling.[6]

From a review of x-rays, Dr. Lucas said claimant's fracture had fully healed. Claimant had no atrophy and no nerve or vascular deficit. He had some tenderness and limitation of motion of the little finger, which Dr. Lucas believed was a residual of the fracture and of the changes that occurred to the soft tissue of the hand. Dr. Lucas said the range of motion measurements of the MCP and PIP joints taken in December 2009 were considerably better than those he found in November 2010. His only explanation for the change was that claimant had not been exercising and allowed his digit to stiffen. Claimant's use of a splint would have inhibited his ability to exercise his finger.

In Dr. Lucas' examination, he found claimant had considerable limitation of motion of the left shoulder. Otherwise, Dr. Lucas found no objective clinical finding relative to claimant's left shoulder. Dr. Lucas said assuming claimant continued to protect his arm since the day of the injury and continued with his splint and sling, the shoulder symptoms and findings would have appeared by the time claimant was seen by Dr. Peterson in December 2009. Dr. Lucas felt it unlikely that adhesive capsulitis would develop if claimant had continued to use his arm and hand to do his exercises and participate in the therapy he was provided. If, on the other hand, claimant had used the sling or simply held his arm close to his side for a majority of his time, that could have led to the development of adhesive capsulitis. From a physiological standpoint, there was no reason for claimant to have a splint on his fractured finger. And as an orthopedic surgeon, he would recommend the opposite. Dr. Lucas said he could not imagine why Dr. Brown recommended claimant use a splint when using his left hand, since the fracture was healed. Dr. Lucas also stated there was no reason for claimant to have used a sling. Dr. Lucas told claimant to stop using both the splint and the sling.

Dr. Lucas opined that claimant was at maximum medical improvement for the fracture of his left little finger and said the impairments in claimant's shoulder are not related to the fractured finger. Based on the AMA *Guides*, Dr. Lucas rated claimant as having a 38 percent impairment of the finger for lack of full MCP joint flexion; a 21 percent of impairment to the finger for lack of PIP joint flexion and a 4 percent impairment for lack of extension; a 5 percent impairment of the finger for loss of DIP joint flexion. These combined for a total 55 percent permanent partial impairment of the left little finger, which converts to a 7 percent impairment to the hand.

After Dr. Lucas released his November 15, 2010, report, he was asked by counsel to the parties to provide an additional opinion regarding claimant's adhesive capsulitis condition. On April 15, 2011, Dr. Lucas provided the ALJ with a report that indicated:

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[6] Claimant testified the only time he ever used a sling was on November 10, 2010, when he traveled to Wichita to be examined by Dr. Lucas.

The question in regard to his shoulder is whether this is a direct result of the hand injury and it is not, but it does appear to be a secondary result. I have seen many patients who have had injuries to their hand or wrist who then develop pain in the shoulder and I believe this is due to adopting a protective posture of the hand or forearm and thereby not moving the shoulder and this induces an adhesive capsulitis. I believe Mr. Amaya does have that and he does have a fair amount of pain in the shoulder . . . .[7]

Dr. Lucas testified as follows:

Q. [by respondent's attorney] If Mr. Amaya was, in fact, continuing to use his arm and hand, normally to do his exercises, to participate in the therapy that he was provided, given what you know about his injury, would you expect that the adhesive capsulitis would develop?

A. [by Dr. Lucas] Not likely.

Q. If, on the other hand, he either used the sling or simply just held his arm close to his side for a major time, or his active waking hours, is this something that would then lead to this ongoing, not ongoing, but the development of adhesive capsulitis?

A. Yes.[8]

Dr. Lucas further testified:

Q. [by claimant's attorney] And one of the physical therapy notes of November 19, 2009, the therapist points out that he was holding his left hand close to the body, and that he suspected that he was limited the use of it. Is that the kind of behavior of developing the adhesive capsulitis problem?

A. [by Dr. Lucas] That's correct.

Q. And that's the opinion that you reach in this case; is that correct?

A. Correct.

Q. And do you have any reason to change the opinion that you expressed in your letter to Judge Moore that the adhesive capsulitis developed secondary to the problems of the original injury?

A. Correct.

Q. You are standing by that position.

A. Yes.

Q. And that's your testimony within a reasonable degree of medical certainty?

A. Correct.

Q. Have any of the questions or what you have seen here today caused you in any way to change your opinion that the adhesive capsulitis is secondary to Mr. Amaya's original injury?

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[7] Correspondence from Dr. George Lucas to ALJ dated April 15, 2011.

[8] Lucas Depo. at 15.

A. Well, secondary in the sense that, that it, that it occurred following a period of protection and immobilization of his arm; but not associated with the original injury.

Q. Sure. But as a natural and probable consequence of the original injury; is that correct?

A. Correct.[9]

Dr. Lucas testified claimant adopted an unnatural behavior in regard to this injury. He said adhesive capsulitis is not the kind of thing that would probably occur when someone fractures a little finger if they follow the usual course of treatment, which would be immobilization for 10 days to 3 weeks and then starting to use it. Dr. Lucas agreed with respondent attorney's that the development of adhesive capsulitis is not something that is a natural thing nor something he would expect to occur in an injury of the type experienced by claimant. But ultimately, Dr. Lucas said he had no reason to change his causation opinion and shoulder rating. He said claimant's adhesive capsulitis was secondary to the work-related accident in the sense that it occurred following a period of protection and immobilization of his arm, but it was not associated with the original injury. He rated claimant as having a 10 percent impairment for pain, a 7 percent impairment for limitation of elevation, a 4 percent impairment for limitation of internal rotation, and a 2 percent impairment for limitation of external rotation. These combined for a total of 21 percent to the left upper extremity at the level of the shoulder.

PRINCIPLES OF LAW

K.S.A. 2010 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends." K.S.A. 2010 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An employer is liable to pay compensation to an employee where the employee incurs personal injury by accident arising out of and in the course of employment.[10] Whether an accident arises out of and in the course of the worker's employment depends upon the facts peculiar to the particular case.[11]

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[9] Lucas Depo. at 18-20.

[10] K.S.A. 2010 Supp. 44-501(a).

[11] *Kindel v. Ferco Rental, Inc*., 258 Kan. 272, 278, 899 P.2d 1058 (1995).

Every direct and natural consequence that flows from a compensable injury, including a new and distinct injury, is also compensable under the Workers Compensation Act. In *Jackson,*[12] the court held:

> When a primary injury under the Workmen's Compensation Act is shown to have arisen out of the course of employment every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury.

ANALYSIS

That claimant has a 5 percent permanent partial disability to his left hand as a result of his July 22, 2009, accident is not in dispute. Therefore, that portion of the ALJ's award will be affirmed. The dispute centers on whether, as a direct and natural result of claimant's compensable hand injury, claimant also has sustained permanent impairment in his left shoulder.

Claimant began experiencing shoulder symptoms in approximately January 2010. At that time, claimant had been released without restrictions by Dr. Peterson with respect to the hand injury. However, claimant did not return to work. Dr. Peterson first noted claimant's shoulder complaints on April 28, 2010. At that time, claimant had pain and restricted motion in his arm and shoulder. Claimant was sent for physical therapy. Eventually claimant was diagnosed with adhesive capsulitis (frozen shoulder due to adhesions) by Dr. Peterson and Dr. Lucas, whereas Dr. Brown diagnosed rotator cuff tendonitis acromial impingement syndrome. Although frozen shoulder can occur for a variety of reasons, with or without trauma, the greater weight of the evidence in this case is that claimant's frozen shoulder condition is due to claimant's disuse of the arm following claimant's hand injury. The Board finds that in addition to his 5 percent left upper extremity impairment at the level of the hand, claimant also has a 20 percent impairment to his shoulder.

CONCLUSION

Claimant developed his left shoulder injury as a direct and natural consequence of his July 22, 2009, work related accident. His resulting impairment is 20 percent to the left upper extremity at the shoulder level in addition to the 5 percent to the left upper extremity at the level of the hand.

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[12] *Jackson v. Stevens Well Service*, 208 Kan. 637, Syl. ¶ 1, 493 P.2d 264 (1972); see also *Logsdon v. Boeing Co.*, 35 Kan. App. 2d 79, 128 P.3d 430 (2006).

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Bruce E. Moore dated June 6, 2011, is affirmed as to the ALJ's award of 5 percent permanent partial disability to the left upper extremity at the level of the hand but modified to find that claimant also has a 20 percent disability to the left upper extremity at the level of the shoulder.

LEFT HAND

Claimant is entitled to 7.5 weeks of permanent partial disability compensation, at the rate of $395.12 per week, in the amount of $2,963.40 for a 5 percent loss of use of the left hand, making a total award of $2,963.40.

LEFT SHOULDER

Claimant is entitled to 45 weeks of permanent partial disability compensation, at the rate of $395.12 per week, in the amount of $17,780.40 for a 20 percent loss of use of the left shoulder, making a total award of $17,780.40.

IT IS SO ORDERED.

Dated this _____ day of September, 2011.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: David O. Alegria, Attorney for Claimant
Kendall R. Cunningham, Attorney for Respondent and its Insurance Carrier
Bruce E. Moore, Administrative Law Judge